HHA PPS MAILBOX QUESTIONS

VOLUME VIII: August 2001 – Batch 1

The questions below, which in some cases have been paraphrased, were sent to *"e-mailto: HHPPS@HCFA.gov"* during the period referenced above. It is our intention to continue to answer questions that come into that mailbox in monthly batches, and post those answers at:*"http://www.hcfa.gov/medlearn/refhha.htm"*. This batch of questions was pulled from the mailbox prior to September 1, 2001. In cases where time is needed to consult internal experts, multiple batches of answers may be released under the same Volume number (same time period or month). Note that questions without broad applicability have been/will be answered/referred individually.

Questions are grouped by topic and not repeated. However, each batch of questions will be listed by topic in order at the beginning of each batch of answers, and a table of cross-references will follow.

Questions by Major Topic

Alphabetical Cross-reference Topics

Therapy: 1
Type of Bill (TOB): 4, 6
Websites: 2, 3, 8

General Terms/Acronyms *(Need to edit against hardcopy)*

The following terms/acronyms may not be spelled out/explained above or elsewhere in this document:

CMS = The Centers for Medicare and Medicaid Services, new name of HCFA (below).

HCFA = Health Care Financing Administration, previous name of the federal agency administering Medicare. Note: The name of the agency was changed to CMS.

HCPCS = HCFA Common Procedure Coding System, individual codes representing medical services or items in Form Locator 44 of Medicare claims

HH = Home Health

HHA = Home Health Agency

HHRG = Home Health Resource Group, the payment group for HH PPS episodes

HIM 11 = Health Insurance Manual 11, the Medicare manual for HHAs.

HIPPS = Health Insurance PPS, a code representing a PPS payment group on a Medicare institutional claim, placed in Form Locator 44

LUPA = Low Utilization Payment Adjustment, a home health episode of four or fewer visits paid by national standard per visit rates.

MSP = Medicare Secondary Payment. Cases where Medicare is the secondary, rather than primary, payer on a claim.

OASIS = Outcome Assessment Information Set. The standard assessment instrument required by HCFA for use in delivering home care.

Outlier = An addition to full episode payment when costs of delivering services exceed a fixed loss threshold.

PPS = Prospective Payment System. A pre-determined method of fee for service payment of bundled services, as opposed to cost reimbursement of individual services, used to pay many types of Medicare providers (hospitals, SNFs, etc.); Medicare pays for home care under a plan of care through a PPS since October 1, 2000.

RAP = Request for Anticipated Payment. The first of two transactions submitted on a UB92 claim form to get the first of two split percentage payments for a HH PPS episode.

RHHI = Regional Home Health Intermediary. Medicare **fiscal intermediary** specializing in the processing of hospice and home health claims.

SNF = Skilled Nursing Facility.

URL= Uniform Resource Locator, address on the world wide web.

AUGUST

CONSOLIDATED BILLING

Q1. *(Part 1 of 2 from this inquiry)* If we had a HH PPS episode open 01/19/01 - 03/19/01, and we discharged the patient on 02/09/01, after which the patient went to a hospital for an outpatient procedure (x-ray barium swallow) on 03/13/01, are we, the home health agency, responsible for the outpatient procedure because it was within the 60-day episode?

A1. The answer to the question is no. While formerly confusion was caused because the hospital outpatient claim would have rejected if filed before the HH claim, when a RAP alone had opened the episode for a full 60 days, this was changed in Medicare claims processing systems in October 2001. Now, such services, not entire claims, will be denied if there is overlap with the period of a HH episode, defined by a received and processed HH claim. Episodes end in the shorter of 60 days or discharge, if earlier, and overlap with a different provider's claims is allowed on a date the patient is transferring between the providers.

In the case above, which was prior to October, and where the patient was already discharged so that there could be no date of service overlap, editing based on the RAP, rather than the claim, probably occurred because the outpatient hospital claim was processed before the HH claim. If this analysis seems correct, suggest the hospital now re-file the previously rejected claim, since there is no overlap in dates of service and the October system fix is in effect even for claims with service dates earlier than October.

Additionally, HHAs are only responsible to pay such providers from the episode payment if the HHAs had already agreed to make such a payment, and if the service is called for under the plan of care they are administering for the episode. Institutional providers like hospitals, and other HHAs, should check the on-line query system, HIQA or HIQH, to see if a HH episode is open before they bill, and if such an episode is open, contact their RHHI to reach the primary HHA to coordinate further care.

RATES and PAYMENT

Q 2. *(Part 2 of 2 from this inquiry)* How do you compute the situation where you have a SCIC, and under the first or second HHRG, there were good number of visits that qualify as an outlier. How do you compute the outlier threshold, as well as the final payment for the episode? Any reference? Please provide an example if possible.

A2. SCICs will be calculated any time more than one HIPPS code appears on an episode claim. A Pricer module embedded in Medicare claims processing software calculates SCIC payment among other adjustments, including whether or not an outlier should be added to total episode payment, for all HH PPS claims, except LUPA claims for four or fewer visits.

Outliers are calculated on a total claim basis, so it makes no difference how many HIPPS codes are reported on the claim. In short, outliers are paid when additional patient need is evidenced on the episode claim by numerous services, and pricing these services on a visit basis exceeds full episode payment, including adjustments like SCICS and PEPs if applicable, and a fixed loss-threshold. If this threshold is exceeded, a percentage of the total service-based reimbursement is added to the episode payment to provide additional payment for unusually demanding patients.

The methodology, with examples, for calculation of full episode payment is in Section IV.F. of the HH PPS final rule. The methodology with an example of calculating an outlier payment can in found in Section IV.E. of the same rule. Other examples can be found in the HH PPS Manual, which, along with the final rule, can be downloaded from the CMS website at:

www.hcfa.gov/medlearn/refhha.htm

Providers may also use the downloadable Pricer PC software to estimate reimbursement available at:

www.hcfa,gov/medicare/nm75ght/pricdnld.htm

Q3. We often have a difference in payment by one or two cents from the HHRG sheet produced by our software, compared to the final episode payment received from our RHHI. Is there a way to correct this rounding difference, and if so, is this an issue I should address with our software vendor or with our RHHI?

A3. Variations of one or two cents between the results of Medicare's Pricer software and the results of vendor software or commercial spreadsheets like Excel are typically caused by variations in rounding. The great majority of calculations within Medicare's Pricer are rounded to two decimal positions at each calculation step. This causes variations with many spreadsheet products since those products often carry more decimal places in their calculations, although only two positions may be displayed on screen. In Excel this can be addressed through using the Tools...Options...Calculation menus and checking the box marked "Precision as Displayed." Other spreadsheet software may have a similar calculation option.

Any rounding variations that are not corrected by the approach above are the result of calculations in which the Pricer carries one calculation out to nine decimal positions before rounding to two positions on a subsequent calculation. An example of this is the application of the wage index. The value that is wage adjusted is multiplied by the labor percentage (.77668) and the result if carried to nine positions. This result is then multiplied by the wage index.

Medicare has no requirements regarding the rounding protocols of software used by either its contractors or providers. Since rounding protocols could vary at any site,

there is no way a RHHI can be required to duplicate the pricing results of all the providers they serve down to the penny.

CLAIMS, ELEMENTS AND CODING

Q4. If a RAP and claim have been filed and paid in full by Medicare, and then were found to have been billed with the wrong HIPPS code because the original OASIS was completed incorrectly, how do we cancel the RAP and the claim? Which one should be canceled first, what code do we use, and how many days does it take for Medicare to cancel the RAP and the claim, or can they be canceled at the same time?

A4. The method used to cancel and RAPs and claims is essentially the same as that used for canceling claims prior to HH PPS. Use type of bill (TOB) 3x8 in Form Locator 4 of the claim format, appropriate condition codes for the cancellation (i.e., D5, D9) in Form Locators 24-30 , and the internal or document control number (DCN) of the previously submitted RAP or claim being cancelled in Form Locator 37, in order to submit a cancellation of either transaction in the claim format.

When a claim has already been paid, the RAP for that episode does not need to be cancelled, since the RAP is routinely cancelled for claims processing and history purposes when the claim is paid. Canceling both a RAP and a claim for a single episode cannot be done, so if both are pending in Medicare systems, providers must wait until they process, at which point they will need only to cancel the claim. A RAP will be canceled when only a RAP has been paid, and the claim is not yet submitted. A claim will be cancelled when both a RAP and claim have been paid, or when just a claim is submitted for the episode (i.e., No-RAP LUPA).

Cancellations are processed in normal billing cycles, which may vary. Like RAPs, cancellations are not subject to payment floors, so therefore they are processed in time frames similar to RAPs. Providers should use their on-line claims history screens in either the FISS or APASS systems to check the status of both RAPs and claims.

However, unlike a RAP, a paid claim may be adjusted rather than cancelled, as seems appropriate in the question above. Adjustments are submitted much as they were before PPS, using TOB 3x7, the appropriate condition code, and the internal or document control number of the claim being adjusted.

Agencies with patterns of changing their HIPPS codes are likely to be subject to medical review. However, case-by-case changes to bring coding in line with submitted corrected OASIS are appropriate.

Q5. Could you please let me know what is happening when a claim is denied because it overlaps with an inpatient claim. When I called Medicare, it was stated we had to cancel the claim with the DCN (or TCN) in question. What exactly is Medicare doing

when this happens: are they canceling the RAP once the claim is canceled, or do we have to resubmit RAPs and claims, or just submit a claim because the RAP was not canceled?

A5. A beneficiary cannot be at home and in the hospital at the same time, so overlapping HHA-hospital billings are not allowed. The logical exception is that both a HHA and a hospital will be allowed to bill specific dates when transfers occur if they shared responsibility for the patient on that day. The concept of simultaneous billing on days of transfer is allowed with other types of providers as well.

Providers should question their RHHIs about directions as given in the question above if they believe there was an error, and there was no overlap of home health service and hospitalization. Interim hospitalizations are allowed during home health episodes, but there should not be any billing by a HHA on days when a beneficiary is in the midst of a hospitalization. If a hospitalization did occur in a beneficiary's episode, and some service or item was billed by the primary HHA on a date of hospitalization other than a date of transfer, such an HH claim would be rejected, since more intensive inpatient service will take precedence over home care.

Once such HHA claims are rejected, as discussed in the question above, rather than denied, back to the provider, they may still be re-billed if changed so that there is no line-item date overlap with the hospitalization. When re-billing the episode, A RAP will only have to be re-billed if it has already been cancelled. If re-billing the RAP, the RAP has to be processed before the claim can be re-billed, unless only a claim will be billed because this is a No-RAP LUPA episode. A No-RAP LUPA episode is one in which an HHA knows an episode will contain 4 or fewer visits, and therefore the HHA has the option to choose not to bill a RAP, only a claim.

Q6. How do we add physical therapy services provided by another provider to our home health bill when services provided during a home health episode?

A6. The question suggests knowledge that what were called "late charge" bills for home health, TOB 3x5, are not allowed under HH PPS. Therefore, such additional charges must be billed by the primary HHA billing the episode. If the claim has already been submitted for the episode, it can be adjusted to submit additional charges. Adjustments are submitted much as they were before PPS, using TOB 3x7, the appropriate condition code, and the internal or document control number of the claim being adjusted. If the claim has not yet been submitted, it should include all charges for the episode, even those of providers subcontracting to the primary HHA. When the claim is paid with all charges for the episode, it is then the responsibility of the primary HHA to pay its subcontractors.

Q7. I would like instructions on how to bill Medicare secondary with HH PPS.

A7. Section 3682.4 of the Medicare Intermediary Manual, first published in Transmittal number 1814 dated November 16, 2000, provides new MSP

requirements for HH PPS. Providers should contact their RHHI if they need instruction in addition to this material. Medicare manuals will be updated if there are any future changes, additions or refinements to this policy.

Q8. I want to download the complete manual for Home Health. I also need to download the complete manual for SNF Long-Term Care Facilities.

A8: To download Medicare Manuals, go to:

http://www.hcfa.gov/pubforms/pubpti.htm

First select: Medicare & Medicaid Manuals (click on the word "Manuals"). Then select "Download Electronic Manuals" (click on this). Scroll down to the manual desired, and click on "Download". For HH, this would be Publication 11, the SNF Manual is Publication 12. Since updating the manuals is a cumbersome process, consider that all manuals may have pending updates.

A special training manual was prepared for HH PPS. The national version of the manual can be downloaded at:

www.hcfa.gov/medlearn/refhha.htm

This URL will take you to a home-health dedicated page on the CMS "Medlearn" (Medicare Learning Network) website. About the middle of this page, you will find a title: "Billing under the Home Health Prospective Payment System". Under this title, you will also find a bullet with a link to the Medicare HH Agency Manual cited above.

Note that many RHHIs also distributed versions of the HH PPS manual with additional information for their providers, so you may also want to contact your RHHI to ask if it would be beneficial to obtain a copy from them. Though the RHHIs have added some additional information based on their experience in educating providers, all the basic information on HH PPS comes from the same manual downloaded from the CMS website.

There is also a SNF PPS training manual. This manual can be found at:

www.hcfa.gov/medlearn/refsnf.htm

Medicare also releases changes in program memoranda (PMs). Program memoranda on HH, SNF or other topics can be found at:

www.hcfa.gov/pubforms/transmit/memos/comm_date_dsc.htm

For SNF, to be aware of changes and current requirements, also select the Program Memoranda for the last 3 years, and save those that mention SNF in the title.

Another source of information on these topics is:

http://hcfa.gov/medlearn/whatsnew.htm

For SNF at this location, scroll down to "Consolidated Billing for Skilled Nursing Facility (SNF) Residents, etc. Click on "Skilled Nursing Facilities".

Further, many fiscal intermediaries, and for home health, RHHIs, also send additional information to their providers. Therefore, for the most complete and timely information, contact your intermediary.